		AND HUMAN SERVICES	zihde	ug.	Tornday	FORM	: 09/12/2017 I APPROVED : 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
POCH	Louis	445500	B. WING		<i>C</i>	09	/07/2017
	PROVIDER OR SUPPLIER	3		14	REET ADDRESS, CITY, STATE, ZIP CODE 106 MEDICAL CENTER DRIVE EBANON, TN 37087	(A)	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157 SS=D	consult with the resconsistent with his representative(s) w (A) An accident invesults in injury and physician intervential (B) A significant chemental, or psychos deterioration in heastatus in either lifeclinical complication (C) A need to alter a need to disconting treatment due to accommence a new for (D) A decision to transident from the fastas. 15(c)(1)(ii). (ii) When making in (14)(i) of this sectionall pertinent informatics available and prophysician. (iii) The facility must resident and the resident and the resident there is-	of Changes. Immediately inform the resident; ident's physician; and notify, or her authority, the resident then there is- olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ilth, mental, or psychosocial threatening conditions or	F 1	57	An in-service will be held with all licensed nurses on 9/22/17 about notification of changes with an explanation of regulation intent. Any patient with a written order potential for error in processing. Protocol will be enforced for a tricheck approach to prevent this ty error. The nurses processing order be educated. Our night shift standouble check for processing accuntrising administration will check next morning to verify correct processing. The DON or her designee will be responsible to verify protocol is followed and complete audits at irregular intervals for accuracy. It will be monitored by QAPI common the processing of the procesing of the processing of the processing of the processing of the	ple ype of ers will f will rracy. the	9/22/2017
BODATOR	, ,	m or roommate assignment DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
NOURAIORI	LINEO TORONO				Administrator		9/20/17

Any deficiency statemen ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PAVILION-THS, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY) IN 1787	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING		MPLETED
PAVILION-THS, LLC CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REQUISION FOR LSC IDENTIFYING INFORMATION) PREFIX 7AG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE RECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETION TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETION TO BE COMPLETION OF THE APPROPRIANTE DEFICIENCY) F 157 Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This RECUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to notify the physician of the family's request to hold a medication order for 1 resident (#65) of 27 residents reviewed. The findings included: Review of facility policy, Change in a Resident's Condition of Status, revised 4/6/16 revealed "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has beenA need to alter the resident's medical treatment significantly" Medical record review revealed Resident #65 was admitted to the facility on 3/20/17 with diagnoses including Alzheimer's Disease, Vascular Dementia with Behavioral Disturbance, Psychotic Disorder with Debusions, Mood Disorder with Depressive Features, Anxiety Disorder, Chronic Pain, Polyneuropathies, Anneid and Pain Province Pain, Polyneuropathies, Anneid and Pain, Polyneuropathies, Anneid and Pain Province Pain, Polyneuropathies, Anneid Pain, Pain Pain Provinc			445500	B. WING			9/07/2017
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to notify the physician of the family's request to hold a medication order for 1 resident (#65) of 27 residents reviewed. The findings included: Review of facility policy, Change in a Resident's Condition of Status, revised 4/5/16 revealed "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been A need to alter the resident's medical treatment significantly" Medical record review revealed Resident #65 was admitted to the facility on 3/20/17 with diagnoses including Alzheimer's Disease, Vascular Dementia with Behavioral Disturbance, Psychotic Disorder with Depressive Features, Anxiety Disorder, Chronic Pain, Polyneuropathies, Anemia and					1406 MEDICAL CENTER DRIVE LEBANON, TN 37087	· · · · · · · · · · · · · · · · · · ·	0
as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to notify the physician of the family's request to hold a medication order for 1 resident (#65) of 27 residents reviewed. The findings included: Review of facility policy, Change in a Resident's Condition of Status, revised 4/5/16 revealed "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has beenA need to alter the resident's medical treatment significantly" Medical record review revealed Resident #65 was admitted to the facility on 3/20/17 with diagnoses including Alzheimer's Disease, Vascular Dementia with Behavioral Disturbance, Psychotic Disorder with Delpressive Features, Anxiety Disorder, Chronic Pain, Polyneuropathies, Anemia and	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETION
Esophagitis. Medical record review of the Quarterly Minimum Data Set (MDS) dated 6/28/17 revealed Resident #65 was severely cognitively impaired.	F 157	as specified in §48. (B) A change in res State law or regular (e)(10) of this section (iv) The facility musupdate the address phone number of the This REQUIREMENT (by: Based on review or review, and interview, and interview the physician of the medication order for residents reviewed. The findings included Review of facility portion (and interviewed) and the resident's Attent (by: The Nurse Superthe resident's Attenthe resident's medical medical record reviewed admitted to the facion including Alzheimer (because of the propersive Feature (by: Depressive Feature (by: Depressive Feature (by: Data Set (MDS) data (many) data (many) data (many).	ident rights under Federal or tions as specified in paragraph on. It record and periodically (mailing and email) and he resident representative(s). The is not met as evidenced facility policy, medical record ew, the facility failed to notify family's request to hold a factor of the interest of the in	F	157		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OECK11

Facility ID: TN9507

If continuation sheet Page 2 of 11

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STATEMENT AND PLAN C	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING			COMP	PLETED	
		445500	B. WING		09/0	7/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 2	F 157			
	Orders Audit dated off Bupropion [antic day] x [times] 1 wk	ew of a Physician's Telephone 7/24/17 revealed "(1) taper depressant] QOD [every other [week], then DC [discontinue], essant] 50 mg [milligrams]"				
	8/2017 Medication order dated 8/8/17	ew of the 7/2017 through Review Report revealed an for Bupropion 100 mg every k then DC and an order dated mg.				*
	on 9/6/17 at 4:05 P station confirmed s Telephone Orders A Resident #65. Furth resident's daughter be held until the da genetic testing resu interview with LPN	nsed Practical Nurse (LPN) #2 M at the 100/200 hall nursing he wrote the Physician's Audit dated 7/24/17 for her interview revealed the requested the 7/24/17 order ughter was able to review the alts for the resident. Continued #2 confirmed the facility failed bing Physician for clarification rder.				
F 278 SS=D	9/6/17 at 4:20 PM in facility failed to noticelarification of the noti	RDINATION/CERTIFIED	F 278			
	must accurately ref (h) Coordination	essments. The assessment lect the resident's status.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OECK11

Facility ID: TN9507

If continuation sheet Page 3 of 11

STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		MPLETED
		445500	B. WING			/07/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	each assessment of participation of head (i) Certification (1) A registered number of the assessment is a sessment is a sessment must see that portion of the a sessment is a sessment in the sessment is a sessment; or (ii) Causes another and false statement subject to a civil modern subject to a civil mode sessment; or (iii) Causes another and false statement is sessment; or (iii) Causes another and false sessment; or (iii) Causes another and false statement is sessment; or (iii) Causes another and false sessment; or sessm	vith the appropriate lth professionals. The must sign and certify that completed. Who completes a portion of the sign and certify the accuracy of assessment. Fication and Medicaid, an individual owingly- Tial and false statement in a line is subject to a civil money than \$1,000 for each Individual to certify a material tin a resident assessment is oney penalty or not more than sessment.	F 2	.78		
	The findings include					
	Medical record review	ew revealed Resident #79 was				

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		445500	B. WING	<i>0</i>	09/0	7/2017
	PROVIDER OR SUPPLIER N-THS, LLC SUMMARY STA	TEMENT OF DEFICIENCIES	1 L	TREET ADDRESS, CITY, STATE, ZIP CODE 406 MEDICAL CENTER DRIVE EBANON, TN 37087 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	N D BE	(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
F 278	diagnoses including Chronic Kidney Dis Aftercare Traumatic Humerus, Pulmona Vascular Dementia, and Anemia. Observation on 9/5, Resident #79 in her darkened bruise on Medical record revis Skin Report written revealed no issue waskin condition. Observation on 9/7, dining room revealed wheelchair seated to meal. Further observation on darkened bruise was now dar Interview with Certif 9/7/17 at 10:50 AM station confirmed stresident used her lehand so the resident into something. Fur CNA was not aware Interview with the Lift on 9/7/17 at 1:45 nursing station conficare to Resident #7	acility on 10/3/14 with g Osteoarthritis, Hypertension, ease Stage 2, Anxiety, c Fracture Bone Right by Embolism/Infarction, Major Depressive Disorder, Majo	F 278	An in-service will be held with all licensed nurses on 9/22/17 about accurate assessment and documentation. Patients receiving medication that affects coagulation are more likely bruising to occur. An audit will be completed on all patients on these drugs to ensure non-pressure skin report assessm are completed and care plans add the potential bruising to guide assessments. The DON or her designee will be responsible to verify audits are completed before 9/22 and again monthly for 3 months and then quarterly until substantial complianchieved. Results will be monitor QAPI committee.	ents ress	9/22/2017

Facility ID: TN9507

		O MEDICALD SEDVICES		0	MB NO.	0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMI	PLETED
		445500	B. WING		09/0	07/2017
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
DV/II IOI	N-THS, LLC			06 MEDICAL CENTER DRIVE EBANON, TN 37087		
PAVILIO				PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	O BE	COMPLETION DATE
F 278	Continued From pa	ge 5	F 278	ž.		
	1:55 PM in the rehat had been providing several days and ha	abilitation Staff #2 on 9/7/17 at abilitation office confirmed she therapy for Resident #79 for ad seen the right hand bruise .she bruises easily"			*	
	Director of Nursing 2:15 PM by the med confirmed the RN h for Resident #79 or confirmed the RN d the skin report, but awhile, at least for 2 on report" When the was to document or "I am to record where ardless of what there" Interview we have the result of th	stered Nurse (RN #1), with the (DON) present, on 9/7/17 at dication cart on the 200 hall had done the skin assessment in 9/6/17. Further interview lid not document the bruise on had "noted the bruise for 2 days, and I put nothing new the RN was asked what she in the skin report the RN stated hatever the skin status is it is or how long it's been with the DON confirmed the urately assess the skin status				
F 279 SS=D	483.20(d);483.21(b) COMPREHENSIVE)(1) DEVELOP E CARE PLANS	F 279			
	assessments comp months in the reside results of the asses	nust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review lent's comprehensive care				
	483.21 (b) Comprehensive	Care Plans				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		445500	B, WING	-		09/0	7/2017
	PROVIDER OR SUPPLIER	À		14	TREET ADDRESS, CITY, STATE, ZIP CODE 406 MEDICAL CENTER DRIVE EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 279	comprehensive per each resident, cons set forth at §483.10 includes measurable to meet a resident's and psychosocial necomprehensive associated plan must describe plan must describe plan must describe physical, mental, arrequired under §483.10, includer §483.24, §48 provided due to the under §483.10, includer §483.10	t develop and implement a son-centered care plan for sistent with the resident rights $I(c)(2)$ and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the ressment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and att would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record.	F	279			

A445500 B. NAME OF PROVIDER OR SUPPLIER	14	FREET ADDRESS, CITY, STATE, ZIP CODE	09/07/2017
NAME OF PROVIDER OR SUPPLIER	14	FREET ADDRESS, CITY, STATE, ZIP CODE	
PAVILION-THS, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL EACH DEFICIENCY MUST BY EACH DEFICIEN	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
Continued From page 7 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of the Non-pressure Skin Report, and interview, the facility failed to follow the care plan to report a change in skin condition for 1 resident (#79) of 27 residents reviewed. The findings included: Medical record review revealed Resident #79 was readmitted to the facility on 10/3/14 with diagnoses including Osteoarthritis, Hypertension, Chronic Kidney Disease Stage 2, Anxiety, Aftercare Traumatic Fracture Bone Right Humerus, Pulmonary Embolism/Infarction, Vascular Dementia, Major Depressive Disorder, and Anemia. Medical record review of the Care Plan dated 7/3/17 revealed Resident #79 was "at risk for potential pressure ulcer development" with Interventions "weekly skin assessment, daily skin inspection, report newareas to charge nurse for evaluation" Observation on 9/5/17 at 2:18 PM revealed Resident #79 in her room in the wheelchair with a darkened bruise on the top of the right hand. Medical record review of the 9/6/17 Non-pressure Skin Report written by Registered Nurse (RN) #1	F 279	An in-service will be held with all licensed nurses on 9/22/17 about accurate assessment and care plan Patients receiving medication that affects coagulation are more likely bruising to occur. An audit will be completed on all patients on these drugs to ensure to care plans address the potential bruising. The DON or her designee will be responsible to verify audits are completed before 9/22 and again monthly for 3 months and then quarterly until substantial compliant achieved. Results will be monitore QAPI committee.	for hat

CENTE	K2 LOK MEDICAKE	& MEDICAID SERVICES		_		()(0) 5 4 = -	OHDVES!
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445500	B. WING	***		09/0	07/2017
	PROVIDER OR SUPPLIER			1.	TREET ADDRESS, CITY, STATE, ZIP CODE 406 MEDICAL CENTER DRIVE EBANON, TN 37087		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	revealed no issue waskin condition. Observation on 9/7/dining room revealed wheelchair seated was now dar. Interview with Certify 9/7/17 at 10:50 AM station confirmed station confirmed station confirmed station with the L. #1) on 9/7/17 at 1:4 station confirmed station.	vas identified regarding the vas identified regarding the vas identified regarding the vas in a soy the table self eating her revation revealed the right hand ker purple in color. fied Nurse Aide (CNA #1) on at the 100/200 hall nursing he had provided care for the days. Further interview vas not aware of the bruise. icensed Practical Nurse (LPN 5 PM at the 100/200 nursing he had provided direct care to her interview revealed the LPN e bruise on the right hand,	F	2279			
F 281	Interview with Reha 1:55 PM in the reha had been providing several days and ha "a few days ago Interview with the D 2:54 PM in the conf "someone didn't foll	bilitation Staff #2 on 9/7/17 at bilitation office confirmed she therapy for Resident #79 for ad seen the right hand bruise she bruises easily" irector of Nursing on 9/7/17 at erence room confirmed	F	281			
SS=D	PROFESSIONAL S (b)(3) Comprehensi The services provid	TANDARDS					
1	,	•					1

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G		MPLETED
		445500	B. WING _			/07/2017
	PROVIDER OR SUPPLIER		20	STREET ADDRESS, CITY, STATE, ZIP C 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 281	This REQUIREMENT by: Based on medical the facility failed to resident (#65) of 27. The findings included Medical record revial admitted to the facincluding Alzheimen Dementia with Behn Disorder with Delus Depressive Feature Pain, Polyneuropat Gastro-Esophagea Esophagitis. Medical record revinorders Audit dated order was written for Bupropion [antideption day] x [times] 1 wk (2) Zoloft [antideption order dated 8/8/17 other day for 1 wee 8/8/17 for Zoloft 50. Interview with Liceron 9/6/17 at 4:05 Pastation confirmed steephone Orders Are and the steephone Orders Are are also provided the steephone Orders Are also provided the steephone	al standards of quality. NT is not met as evidenced record review and interview, follow a physician's order for 1 residents reviewed. ed: ew revealed Resident #65 was lity on 3/20/17 with diagnoses r's Disease, Vascular avioral Disturbance, Psychotic sions, Mood Disorder with es, Anxiety Disorder, Chronic hies, Anemia and I Reflux Disease without ew of a Physician's Telephone 7/24/17 revealed the following or Resident #65 "(1) taper off ressant] QOD [every other [week], then DC [discontinue] essant] 50 mg [milligrams]" ew of the 7/2017 through Review Report revealed an for Bupropion 100 mg every ek then DC and an order dated	F 28	F281 Services provided to a professional standards An in-service will be held w licensed nurses on 9/22/17 processing physician orders. Any patient with an order a potential for error in processing for the protocol will be enforced for check approach to prevent error. The nurses processing be educated. Our night ship check for processing accurate administration will check the morning to verify correct pure proposible to verify protocol followed and complete auditive intervals for accurate will be monitored by QAPI.	ith all about s	9/22/2017

CENTE	42 FOR MEDICANE	& MEDICAID SERVICES	1		(V2) DATE	CHDVEV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445500			09/0	7/2017
	PROVIDER OR SUPPLIER	6		STREET ADDRESS, CITY, STATE, ZIP CODE 1406 MEDICAL CENTER DRIVE LEBANON, TN 37087		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	be held until the dar genetic testing result interview with LPN: Medication Review not 7/24/17 as writte Interview with the D 9/6/17 at 4:20 PM in Physician's Order day was not started until the facility failed to	requested the 7/24/17 order ughter was able to review the lts for the resident. Further #2 confirmed the order on the Report was dated 8/8/17 and	F 281			
						R